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Title Page

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A qualitative study of women's views on the acceptability of being asked about mental health problems at antenatal booking appointments

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Conflict of Interest

Louise Howard chaired the National Institute for Health and Care Excellence CG192 guidelines development group on antenatal and postnatal mental health in 2012-4.

Ethical Approval

The research was approved by the National Research Ethics Service, London Committee - Camberwell St Giles (reference number: 14/LO/0075).

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ABSTRACT

Objective

To explore women's views on the acceptability of being asked about mental health problems at antenatal booking.

Design

Qualitative study.

Setting

Brief semi-structured qualitative interviews were conducted with women in a private setting at a hospital, or at women's homes. Interview discussions centered around three key questions: "What was it like for you answering the questions about your mood?", "Were there any questions you found upsetting, distressing or confronting?" and "Did the midwife give you some feedback about your answers?"

Measurements

Interviews were audio-recorded, transcribed verbatim, and analysed using thematic and framework approaches.

Participants

An ethnically diverse sample [32% white British/Irish, 68% non-white, non-British] of 52 women living in the study area.

Findings

Most women found mental health enquiry acceptable. A smaller proportion reported difficulties and many of these women had a past or current mental health problem and/or a history of abuse. These women reported difficulty due to the emotional responses triggered by the questions and the way disclosures were handled. In general, women wanted to be asked clear questions about mental health problems, to have sufficient time to discuss issues, and to receive responses from midwives which were normalising and well-informed about mental health.

Conclusions

This study highlights that women want midwives to ask clearly-framed questions about mental health problems [addressing past and current mental health concerns], and valued responses from midwives that were normalising, well-informed and allowed for discussion.

Implications for Practice

Training should be provided to midwives on how to appropriately respond to women's distress during mental health enquiry, and on referral to support services.

Key words

Prenatal Care; Qualitative Research; Midwifery; Depressive symptoms ; Mental health

INTRODUCTION

Depression is common in the perinatal period, with estimates from high-income countries ranging from 9-11% in pregnancy and 6-13% in the year post child-birth (Howard et al., 2014). Pregnancy does not seem to be protective, with rates of depression similar among pregnant and non-pregnant women of childbearing age (Howard et al., 2014; Vesga-López et al., 2008) .

Depression in pregnancy is associated with obstetric complications, including low birth weight in babies (Stein et al., 2014). Antenatal depression is also a predictor for postnatal depression (Leigh & Milgrom, 2008) and evidence shows that postnatal depression can have negative impacts on mother-and-infant interactions, the cognitive development of infants (Milgrom, Westley, & Gemmill, 2004) and depression in young adults (Pearson et al., 2013; Stein et al., 2014).

Around half of all antenatal mental health problems go unrecognized by health care professionals (Ramsay, 1993), despite frequent contact with healthcare services throughout the pregnancy period (Kelly et al., 1999). Thus, routine case-finding for antenatal depression has been advocated in many countries including the United States (US), Australia, and the United Kingdom (UK). The Edinburgh Postnatal Depression Scale (EPDS) is routinely used to assess for antenatal depression in Australia (National Perinatal Depression Initiative (NPDI), 2010), and in the US routine case-finding is recommended using either the EPDS or the two-item Patient Health Questionnaire (PHQ-2) (O'Connor, Rossom, Henninger, Groom, & Burda, 2016). The PHQ-2 might be considered favourable for implementation on account of its brevity, as it only asks if people have been affected by: (1) little interest or pleasure in doing things, or (2) feeling

down, depressed or hopeless, in the past two weeks. This measure is scored using either a “yes”/”no” response format or a Likert scale.

The PHQ-2 demonstrates good sensitivity and specificity in non-perinatal samples (Li, Friedman, Conwell, & Fiscella, 2007; Mitchell, Yadegarfar, Gill, & Stubbs, 2016), but somewhat varies within the perinatal population. When administered in early pregnancy (using the “yes”/“no” format) and compared against the EPDS, a US study reported a PHQ-2 sensitivity and specificity value of 93% and 75%, respectively (Bennett et al., 2008). However, a recent systematic review by the US Preventive Services Task Force examined studies that compared the PHQ-2 against a validated diagnostic interview in the perinatal period. The authors concluded that the sensitivity and specificity of the PHQ-2 was wide-ranging in light of the different scoring methods, cut-offs, and diagnostic interview comparators used; the specificity was marginally better for the Likert scale response version, which may indicate reduced false positives with this scoring method (O’Connor et al., 2016).

In the UK, the National Institute for Health and Care Excellence (NICE) recommends two alternative case-finding questions for depression (the Whooley questions; Whooley, Avins, Miranda, & Browner, 1997) be asked at women’s first appointment with their midwife; this is around 10 weeks gestation, and is known as an antenatal booking appointment (National Institute for Health and Care Excellence, 2014). The two questions are related to the PHQ-2; asking the same two questions but over a different time period (during the past month). The Whooley questions are scored using a “yes” or “no” response; a “yes” answer to either of the two questions denotes a positive screen. Recent evidence from a large UK cohort study of 545 pregnant women examining the diagnostic-accuracy of the two Whooley questions and the EPDS against a gold-

standard diagnostic clinical assessment of psychiatric disorders (the Structured Clinical Interview for DSM-IV (SCID)), found that the Whooley questions are effective at identifying depression and other mental health problems in early pregnancy (Howard et al., 2018). The Whooley questions have also been found to be more cost-effective than the EPDS in antenatal samples when followed by a longer version of the PHQ-2: the PHQ-9 (Littlewood et al., 2018).

Despite growing evidence of the diagnostic accuracy of case-finding questions for antenatal depression, little is known about pregnant women's views on their experience of being asked. The majority of qualitative research in this area has focused on the postnatal period and the acceptability of the EPDS (El-Den, O'Reilly, & Chen, 2015; Leigh & Milgrom, 2007), with one exception that focuses on the early antenatal period, but among an ethnically homogenous sample and solely among women meeting clinical-thresholds for mental health problems(e.g. Darwin, McGowan, & Edozien, 2016). A recent UK qualitative research study examined the acceptability of the Whooley questions throughout the perinatal period (Littlewood et al., 2018). Researchers asked both women and health professionals a number of questions about the acceptability of the Whooley questions, and subsequently conducted semi-structured interviews to probe this information in more detail. Perinatal women reported difficulties with the wording of the questions, fears of the consequences of a disclosure, and discussed the stigma associated with mental health problems. Health professionals reported that they were generally comfortable with using the Whooley questions routinely, but expressed that they did not feel comfortable asking them to women who had suffered significant trauma, or who had a history of mental health problems. This raises important questions around whether women with histories of trauma or mental health concerns have different experiences of the Whooley questions, when asked by health

professionals. In addition, it is unclear what women's experiences are of being asked the Whooley questions at their antenatal booking appointments, as the Littlewood study examined the acceptability of these questions in a research setting, rather than in healthcare practice.

This study, therefore, seeks to address current evidence gaps by exploring the experiences and views of midwives' enquiry of antenatal depression, among a diverse sample of women who have attended their antenatal booking appointment in an inner-city UK service.

METHODS

Consolidated criteria for reporting qualitative research (CORE-Q) guidelines have been followed; the CORE-Q is a checklist summarising good practice for reporting qualitative research studies (Tong, Sainsbury, & Craig, 2007). This study analysed qualitative data from a larger cohort study which aimed to investigate the diagnostic accuracy of the Whooley questions and the EPDS against the Structured Clinical Interview DSM-IV (SCID) (Howard et al., 2018). The research version of the SCID for Axis I Disorders (DSM-IV-TR) is a semi-structured interview of standardised diagnostic questions to determine DSM-IV Axis I diagnoses. The modules on mood episodes, mood disorders, anxiety disorders, and eating disorders were used in this research. Similarly, the Structured Clinical Interview for DSM-IV Axis II Disorders (SCID-II) is the equivalent tool for Axis II diagnoses (personality disorders); the module on borderline personality disorder was used for this research. This study was conducted at King's College Hospital, which serves an ethnically and socially diverse inner-city population.

Procedure

Women aged 16 years and older who completed an antenatal booking appointment at King's College Hospital between 10th November 2014 and 30th June 2016 were invited to take part in a research study on well-being in pregnancy. A study advert was included in the pre-booking information pack, and online audit-trailed randomisation for enrolment into the study was carried out by trained researchers (research midwives and post-graduate research psychologists), once Whooley status ("positive"/"negative") had been recorded by midwives. All women attending booking appointments were expected to be asked the Whooley questions by their midwives (National Institute for Health and Care Excellence, 2014; Redshaw & Henderson, 2016). As the hospital

conducts on average 500 antenatal booking appointments per week and the majority of pregnant women will have negative screens - i.e. a "no" response to the two depression questions - we randomly selected for potential enrollment (initially at a ratio of 1:4 and then 1:6) the women who screened negative to the questions. We attempted to recruit all women who screened positive. From 10th November 2014 to 30th June 2016, of the 882 Whooley negative women that were eligible, 624 (71%) did not participate and 478 (62%) of the 765 eligible Whooley positive did not participate; further details on reasons for non-participation are available elsewhere (Howard et al., 2018). Therefore, the cohort study comprised a total of 545 women, 287 Whooley positive women, and 258 Whooley negative women.

Face-to-face interviews were carried out by trained female researchers in a private room at the hospital or at women's homes (for more details, see: Howard et al., 2018). Researchers were experienced midwives or post-graduate research psychologists who undertook detailed training on mental health problems, good clinical practice and information governance. Researchers did not have any relationship with participants prior to the study. Written informed consent was obtained from all participants; as part of this process, researchers explained that the study intended to investigate healthcare responses to women's emotional well-being in pregnancy.

As part of the wider interview (Howard et al., 2018), researchers asked some brief semi-structured questions about women's experiences of being asked about depression at their booking appointment. Interview discussions centered around three key questions:: "What was it like for you answering the questions about your mood?", "Were there any questions you found upsetting, distressing or confronting?" and "Did the

midwife give you some feedback about your answers?" (Leigh & Milgrom, 2007). Interviews were audio recorded with permission from the women; no additional field notes were recorded. The average duration of the discussion was 00:02:46 (range 00:00:51 to 00:06:48). Interviews were anonymized and transcribed verbatim; participants were not asked to comment on the transcripts or overall findings.

Ethics

Ethics approval was granted from the Camberwell St Giles Research Ethics Committee, London (reference 14.LO.0075). All participants gave written informed consent.

Sample

A purposive sample of the narratives of 52 women was selected for this qualitative study. Purposive selection of cases was undertaken to ensure that the final sample reflected both the socio-demographic and psychiatric diversity of the sample as a whole. Further criterion was later applied to the selection of purposive cases, in order to ensure that narratives accurately described the area under investigation. This was due to the fact that some women did not recall being asked the Whooley questions by their midwife (n=10); these transcripts were therefore deemed unsuitable for analysis. Demographic and clinical characteristics of the sample are outlined in Table 1 in the results section.

Analysis

The narratives of 52 women were selected to ensure saturation of themes was reached. Narratives were analysed using thematic and framework approaches (Attride-Stirling, 2001; Boyatzis, 1998; Braun & Clarke, 2006; Ritchie & Spencer, 1994), and the data

managed in NVivo11. Thematic analysis approaches were first employed and involved: familiarisation with the data; the generation of initial codes; thematic development and the establishment of a thematic coding frame (Braun, Clarke, & Terry, 2014). Three key stages of framework analysis were then applied: charting, mapping and interpretation (Ritchie & Spencer, 1994). Framework analysis offers a structured and organised approach to the management of thematic analysis (Ward, Furber, Tierney, & Swallow, 2013), and has been previously used in midwifery research on women's mental health (Furber, 2010). It was not assumed that themes would 'emerge' from the data but that interpretive work would be needed to identify them.

Following familiarisation and immersion with the data - which involved reading and re-reading of the transcripts - intense, line-by-line open coding of each transcript was conducted by two raters (MK and LT); generating an initial coding frame, based on thematic categories rooted in the data. The appropriateness of the coding frame was checked through progressive iterations and reapplied to earlier transcripts as it developed. The appropriateness of the coding frame was then examined by two independent raters (KT and EY), and all of the coding was cross-checked to ensure reliability. Data that did not seem to fit into the coding frame were actively sought and multiple coding conducted by the two raters (KT and EY); differences were discussed, and agreement sought before the coding frame was amended and refined. As part of this process, codes with similar information were merged and irrelevant codes pruned. Inter-rating was carried out at various stages in the process and a final inter-rater agreement of 93% was attained. The resulting coding frame was then summarised into thematic charts, using the NVivo11 Framework Matrices functions (Gale, Heath, Cameron, Rashid, & Redwood, 2013), and mapped to facilitate exploration of patterns and associations within and across transcripts and comparisons across themes.

Interpretation was then conducted to synthesise the data (Ritchie, Spencer, & O'Connor, 2003), through the generation of explanatory accounts of the data, and to establish a finalised theoretical framework.

Reflexive practice by the researchers highlighted ideological motivations (e.g. Feminism) and individual characteristics (e.g. age, lived experience, class, English monolingualism) that were considered to enter into the analysis process. The two independent raters adopted subtle realist (KT) and critical realist (EY) epistemological approaches, such that author biases and perspectives were constantly and consistently evaluated in order to generate a more complete understanding of the findings.

RESULTS

Three dominant themes were identified in the coding tree: (1) the experience of being asked about depression, (2) the experience of answering the questions, and (3) the approach of the midwife. While women did not object to the Whooley questions themselves, some experienced difficulty with the enquiry – either because they found it painful, feared the consequences of a disclosure, or felt that their experience had not been validated and normalised by their midwife. Framework analysis highlighted that the majority of women spoke of the questions being acceptable to ask, and that nearly all of the women who reported issues or difficulties with the questioning presented with some combination of: a positive screen on the Whooley questions, a current diagnosis of a mental health problem as measured by the SCID, a disclosure of previous mental health issues, or a history of interpersonal abuse. No patterns or associations in the data were identified when examining women's ethnicity, immigration status, or age. Presentation of themes will ensue with the use of illustrative quotes to support thematic content, focusing on the factors influencing acceptability and difficulty within the three dominant themes.

Table 1. Characteristics of sample

Age (years)	*M*=31.77, *SD*=6.76 (17-45)
Ethnicity White Black British Black Caribbean / African Asian / Other	 27 (51.92%) 6 (11.54%) 12 (23.08%) 7 (13.46%)
First language – English	34 (65.38%)
Has other children	24 (46.15%)
Positive screening for depression questions	27 (51.92%)
Any Structured Clinical Interview for DSM-IV (SCID) diagnosis Met SCID criteria for:	26 (50.00%) 16 (30.77%)

Depression Disorder	6 (11.54%)
Post-traumatic Stress Disorder	17 (32.69%)
Anxiety Disorder	7 (13.46%)
Other	16 (30.77%)
Comorbidity	
Immigration status	
United Kingdom National	33 (63.46%)
Indefinite leave to remain	5 (9.62%)
European Economic Area citizen	6 (11.54%)
Other	8 (15.38%)
History of interpersonal abuse	17 (32.69%)

THEME ONE: THE EXPERIENCE OF BEING ASKED ABOUT DEPRESSION

The main themes identified with regards to women's experiences of being asked about mental health was their emotional response to the questions, the effect of the presence of others during the enquiry, and of the wording of the Whooley questions themselves.

Emotional responses: ***"It wasn't the questions that were upsetting but how I was processing those questions"***

Women did not object to being asked the brief depression questions, but some found responding to them difficult. Of the women who found the questions difficult, this was often either on account of coming to terms with their current mental health problems, or due to the questions eliciting difficult memories:

> *"I didn't find it upsetting or distressing but I found it kind of confronting. Because it made me then have to stop and think a little bit more about how, 'oh how have I actually been feeling kind of mentally?'" (155, positive Whooley screen, no SCID diagnosis, history of interpersonal abuse)*

"It's a tough thing to admit fully at first… when the tears come you just feel too bad remembering everything that has happened, it's something that you can't actually comprehend at all." (220, positive Whooley screen, SCID diagnosis, history of interpersonal abuse)

The difficulties experienced by these women did not reflect a general objection to this form of enquiry, but rather the result of the overwhelming emotional responses triggered by the questions. As exampled by one woman:

"It wasn't the questions that were upsetting but how I was processing those questions, because it is a normal question people ask me: 'oh, how are you doing?' but I would just think of my state and have these flashbacks again and that's why I was upset, but not because of the actual questions themselves." (409, positive Whooley screen, SCID diagnosis, history of interpersonal abuse)

Most women spoke of the importance of being asked about mental health, or the reassurance of knowing that support was available:

"I think it's important not only to talk about bodily health but also mental health because it's quite a roller coaster ride to be pregnant I have to say." (128, positive Whooley screen, no SCID diagnosis, no history of interpersonal abuse)

"It was comforting to know that there was support if ever I did feel that I needed it." (288, negative Whooley screen, no SCID diagnosis, no history of interpersonal abuse)

The presence of others: *"I mean my boyfriend was there as well…"*

There were individual differences among women regarding the preference for having others present during midwives' enquiry about mental health. Some felt that the presence of a supportive other was positive:

> *"I think at first I wanted to lie and say that 'no everything is fine', but my partner encouraged me that 'obviously if you don't, if you're not honest then you're not going to get the help that you may need in the future.'" (011, positive Whooley screen, SCID diagnosis, history of interpersonal abuse)*

Whereas for others the presence of another person was perceived as a hindrance:

> *"I mean my boyfriend was there as well… he knows how I've been feeling but I think it's probably something I would prefer to talk about just with midwives there." (022, positive Whooley screen, SCID diagnosis, no history of interpersonal abuse)*

The wording of the Whooley questions: *"It's a good thing the questions were as they were" / "It was very like black or white"*

Women described different experiences in relation to how midwives asked about depression. Some reported that midwives used clear and specific descriptions about mood fluctuations and changes in behaviours, which they found particularly helpful in clarifying their feelings:

"I think I'd not really thought about it as feeling depressed until that moment. Just thought that I'd become quite withdrawn and very moody… It's a good thing the questions were as they were, and worded as they were, as they helped me to address things." (001, positive Whooley screen, SCID diagnosis, no history of interpersonal abuse)

Others spoke of how midwives used less clear or vague language, which resulted in confusion about what the questions were trying to elicit. As the comment below highlights, the specificity helped to gain clarity about the purpose of the enquiry:

"Just the way 'how have you been feeling?' I suppose you generally think about your medical symptoms, not necessarily how emotionally you have been feeling… when she [midwife]… said 'and have you, like, had the same sort of wanting to do things?' and things… that was kind of more clear." (005, negative Whooley screen, no SCID diagnosis, no history of interpersonal abuse)

Some also reported that the questions were problematic to answer, as they required a "yes" or "no" response and this may have limited the opportunity to explore women's feelings:

"I definitely felt a little bit down but… it was very like black or white, 'yes' or 'no' kind of thing whereas I kind of felt like I was more in a slightly grey area." (112, negative Whooley screen, no SCID diagnosis, no history of interpersonal abuse)

THEME TWO: THE EXPERIENCE OF ANSWERING THE QUESTIONS

Women's experiences of answering the Whooley questions were affected by several factors: fears about the implications of disclosure, a desire to seek support, and the contextual constraints of the antenatal booking.

Implications of disclosure: *"If I say that yeah I am struggling with something, what will happen next?"*

Some women expressed concerns about the potential consequences of making a disclosure, partly due to a lack of assurance in how the information will be handled or shared:

> *"There is always that 'okay if I say that "yeah I am struggling with something", what will happen next?'" (147, positive Whooley screen, SCID diagnosis, no history of interpersonal abuse)*

Several women expressed concern that a disclosure may result in midwives alerting safeguarding services:

> *"There is always still that slight chance that if professionals think that I'm struggling, are they going to step in and think my other children need help?" (ID147, positive Whooley screen, SCID diagnosis, no history of interpersonal abuse)*

Some women also spoke of how the stigma surrounding mental health might contribute to doubts about their parenting ability:

"You kind of feel like people might be judging you slightly, the fact that you've got a psychiatric history when… you have a child. So slightly uncomfortable." (152, positive Whooley screen, SCID diagnosis, history of interpersonal abuse)

In contrast, a few women did not report any worries about disclosure and welcomed the opportunity to talk:

"I find it very therapeutic actually, to just let it out and express myself to somebody who doesn't know me, and has a complete fresh perspective." (440, positive Whooley screen, SCID diagnosis, history of interpersonal abuse)

Desire to seek support*: "I've just got to let it out otherwise I won't get the help that I need"*

When women were forthcoming with a disclosure, this was coupled with a desire to ascertain support or to facilitate a discussion about their well-being:

"At first I felt like I didn't go into much detail but then I just thought, you know, I've just got to let it out otherwise I won't get the help that I need." (440, positive Whooley screen, SCID diagnosis, history of interpersonal abuse)

"You don't know where your help can come from…So… I just had to open up to her [midwife] and… talk about it." (341, positive Whooley screen, SCID diagnosis, history of interpersonal abuse)

Contextual constraints of the antenatal booking: *"It was all a little bit rushed"*

Some women spoke about the effects that the context of the questioning had on their answers. Several acknowledged the time pressures on midwives at the booking appointment. They spoke of how the midwives have many tasks to complete during the booking appointment and as a result discussions about mental health felt rushed:

> *"It was all a little bit rushed, and, you know, there's a lot to fit into that, which is not her [midwife] fault, but, kind of how the system works. You can see that. But… I just felt a bit… It wasn't that satisfying really." (ID020, negative Whooley screen, no SCID diagnosis, no history of interpersonal abuse)*

> *"There were a lot of questions and that was just part of it… it felt like an appointment where certain things had to be done you know… I don't feel like there was… room…" (022, positive Whooley screen, SCID diagnosis, no history of interpersonal abuse)*

THEME THREE: THE APPROACH OF THE MIDWIFE

The approach of the midwife was spoken about often and factors contributing to the satisfaction of the enquiry included: the comfort of the midwife in discussing mental health (whether current or historical), and their knowledge about support options.

Midwife confidence and competence in addressing mental health problems: *"She was quite knowledgeable on the topic" / "I wish I'd never said anything"*

Women valued it when midwives sought to contextualise and normalise their

experiences:

> *"She [midwife] said that… 'it's perfectly normal' that 'you know, lots of people go through the same thing' and she allowed me to just have a little moment really." (141, positive Whooley screen, SCID diagnosis, no history of interpersonal abuse)*

When this did not occur, women felt dissatisfied:

> *"Maybe there was an element of just wanting to be reassured that maybe it was a bit normal to have those feelings, I don't know." (022, positive Whooley screen, SCID diagnosis, no history of interpersonal abuse)*

Women reported mixed experiences with midwives' confidence and competencies to address mental health. Some spoke of how their midwife was well-informed about mental health, and through their discussions they developed knowledge and strategies to support them during the pregnancy:

> *"She did give me some advice…given she was the expert in…maternal matters, I… I was reassured that she felt that she was quite knowledgeable on the topic." (083, negative Whooley screen, SCID diagnosis, no history of interpersonal abuse)*

Others, however, reported that their midwife appeared to lack confidence in addressing mental health. They felt that the midwife was not open to discussing their experiences:

"I just thought I'd mention it, maybe we could talk about it, but I didn't get anything from her, and I was kind of disappointed and I wish I'd never said anything." (020, negative Whooley screen, no SCID diagnosis, no history of interpersonal abuse)

Sometimes women felt the midwife was more eager to refer them onto a different service, and consequently unable to offer reassurance:

"The suggestion to kind of have a doctor's appointment, it felt like I don't want a doctor's appointment, you know." (022, positive Whooley screen, SCID diagnosis, no history of interpersonal abuse)

This led some to feel that the questioning around mental health was not considered important and the process was perceived as simply a tick-box exercise:

"The way that the whole interview/booking appointment was conducted… it felt a bit more of a tick-box exercise, to be honest, than asking me how I actually was." (152, positive Whooley screen, SCID diagnosis, history of interpersonal abuse)

Relatedly, some women expressed difficulties with the constraints of diagnoses. Women found that midwives were not able to explore the impact of current or previous mental health issues other than depression, due to the specificity of the screening:

"I think what I was just trying to say is that I still have anxiety about whether this pregnancy will actually happen, but I think that's because when you go through

IVF, you are, it's a complicated emotional roller-coaster. I think she [midwife] was, because I didn't fit into the box she had to tick, she, she just kept asking the sort of same question and I was like 'I'm not, I'm not depressed.'" (096, positive Whooley screen, no SCID diagnosis, no history of interpersonal abuse)

Others described the tendency for midwives to focus on diagnosing current mental health issues, which resulted in dissatisfaction with disclosing prior mental health problems:

"I said I had a history of anxiety… rather than like 'are you ok now? Are you feeling anxious?'… it was more like, 'check she's not anxious now' and then they [midwives] were like 'make sure you write that down, make sure you write down that she's not anxious right now'…I felt a bit more like it was not actually monitoring whether I was anxious, it was more sort of making sure that it was recorded that I wasn't anxious at that point." (015, negative Whooley screen, SCID diagnosis, history of interpersonal abuse)

DISCUSSION

Although most women found mental health enquiry by midwives at antenatal booking acceptable, several reported difficulties; many of these women had a past or current mental health problem and/or a history of abuse. Framework analyses indicated that negative experiences were not affected by either ethnicity, immigration status, or age. Women who had disclosed a current or past mental health problem and/or a history of abuse reported difficulty due to the emotional responses triggered by the questions and the way disclosures were handled. Many of these women felt anxious about the stigma surrounding mental health and were fearful of being judged for their parenting capabilities and of the prospect of social services intervening. Others felt as though they had not been heard, either on account of the booking appointment feeling rushed, like a tick-box exercise, or if they felt as though the midwife had not validated their disclosure. Women placed value upon responses from midwives which were normalising and well-informed about mental health, as this facilitated the opportunity to explore their feelings and to be informed about sources of support.

Differences in women's satisfaction with enquiry

Our study highlights that some women find mental health enquiry challenging, as it prompts them to remember distressing past memories or to confront mental health concerns. Most of the women in our study who experienced difficulty with enquiry presented with a current or historic mental health problem and/or a history of interpersonal abuse. A relationship between these factors and difficulty with antenatal depression screening has not been established previously among antenatal women (Clark, 2000; Flynn, Walton, Chermack, Cunningham, & Marcus, 2007; Leigh & Milgrom, 2007; Littlewood et al., 2018). However, research conducted with health professionals

indicates that their comfort with routine antenatal mental health enquiry may be compromised for women who have suffered significant trauma or who have a history of mental health problems (Littlewood et al., 2018).

Our findings reflect some UK midwives' lack of training and subsequent discomfort with enquiry into mental health. Research finding that antenatal depression screening is acceptable has been conducted with midwives who received comprehensive training (Leigh & Milgrom, 2007), and health visitors who had enduring relationships with the women they screened; a factor which was cited as putting professionals at ease when asking the depression questions (Clark, 2000). Research with UK midwives and midwifery students indicates that they may feel uncomfortable about asking women both the Whooley questions and about their experiences of abuse, particularly because they do not receive adequate training in mental health and feel poorly equipped to handle disclosures (Bradbury-Jones & Broadhurst, 2015; McGlone, Hollins Martin, & Furber, 2016; Mezey, Bacchus, Haworth, & Bewley, 2003).

The prevalence and co-existence of antenatal depression, interpersonal violence, and other mental health problems is relatively high within antenatal samples (Connelly, Hazen, Baker-Ericzén, Landsverk, & Horwitz, 2013; Flynn et al., 2007; Melville, Gavin, Guo, Fan, & Katon, 2010), particularly within urban (Melville et al., 2010) and culturally-diverse populations (Connelly et al., 2013). This is reflected in our sampled population, where 1 in 4 women present with a mental health problem (Howard et al., 2018), and in our purposive sample, as 30% of women had a co-morbid mental health problem and 32% a history of interpersonal violence. In consideration of this high prevalence,

midwives may need to be better equipped to handle disclosures of mental health problems and interpersonal abuse.

Midwife enquiry as a facilitator to disclosure

Some women in this study found it a positive experience to be asked about mental health by their midwife at antenatal booking, though this was contingent on the midwives being confident and well-informed about mental health. Direct enquiry by a midwife helped to encourage disclosure and facilitate general discussions about women's experiences and needs. Dissatisfaction was significant among the women who had mental health problems and/or histories of abuse, as they were unsure about the potential implications of disclosure and fearful of social services' involvement if they were perceived as unable to cope.

Women wanted to receive responses from midwives which normalised and validated their experiences. They advised midwives to describe specific symptoms and behaviours, as this helped them to identify any issues, and whether they were "normal" or not. Difficulty arose where midwives were likely under-confident on the topic of mental health: some women felt that the questions were performed like a tick-box exercise, and commented on the midwife's tendency to focus on determining a diagnosis of depression or at the time of booking, inhibiting the development of support plans for women concerned about other mental health issues.

Factors identified in this study that contribute to women's satisfaction with mental health enquiry echo previous work with perinatal women. Studies of postnatal women cite the opportunity to talk about mental health as of primary importance (McCarthy & McMahon, 2008). Similarly, perinatal women report difficulty determining whether their emotional experiences are "normal" (Kingston et al., 2015), and express fear of being perceived as an incapable mother if they are not (McCarthy & McMahon, 2008)(Shakespeare et al., 2003). Research on the acceptability of perinatal mental health screening in the UK has also established that women perceive the Whooley questions somewhat like a tick-box exercise in an otherwise medical assessment (Darwin et al., 2016)(Littlewood et al., 2018). Health professionals can therefore encourage disclosure of antenatal mental health problems by initiating a general discussion around mental health, in addition to the Whooley questions, and by reassuring women of the normalcy and validity of these experiences (National Institute for Health and Care Excellence, 2014). A Canadian study on barriers and facilitators to antenatal mental health screening among 460 pregnant women found that disclosures can be facilitated by highlighting how common perinatal mental health problems are, and by explaining to women what they can expect from services if they disclose concerns (Kingston et al., 2015).

Context of enquiry

Women in our study spoke of the need to ensure that sufficient time is given for the exploration of mental health problems during the appointment, and there were mixed feelings surrounding both the presence of others during questioning and the phrasing of questions about mental health: the specificity of the questions was received positively, but their warranting a binary answer was considered problematic. Although systemic

constraints on time have previously been cited as a barrier to disclosures among postnatal (Shakespeare et al., 2003) and antenatal women (Darwin et al., 2016), such limitations are not easily addressed. There are, however, several other factors identified in the current research and reflected in work on postnatal depression that would be easily implemented to improve the acceptability of the Whooley screening at antenatal booking appointments, therefore, we note several implications for practice.

Implications

Research suggests that women want discussions about emotional health to be part of routine antenatal health care (Kingston et al., 2015), and the NICE guidelines on antenatal and postnatal healthcare have emphasised the importance of facilitating general discussions around mental health which acknowledge and address the fact that women who are concerned about their mental health may fear being perceived as incompetent mothers (National Institute for Health and Care Excellence, 2014). Our results re-iterate the importance of these principles, and the fact that adequate training must be provided in order to implement them. For enquiry to be viewed favourably by women, midwives first and foremost need to be prepared to listen to and validate any disclosures that are made. Midwives should acknowledge disclosures of current mental health problems by reassuring and normalising the problem, and concerns about past or prevailing mental health problems should be properly explored to establish the appropriate or desired means of support. Some women may solely be seeking a discussion, but others may be comforted by information on sources of support, referrals, or the development of a plan of action. Further, where women are not forthcoming with a disclosure, it would be instructive to reassure them that any mental health concerns are not indicative of their performance as a parent, but in fact very

common and easily accommodated. Finally, women should be given the opportunity to disclose mental health problems without a partner or other family member present, for although some people wanted their partner present, for others, the presence of their partner was a barrier to case identification.

Limitations

There are several limitations to this study that should be considered when interpreting these findings. This study was conducted in a culturally diverse urban setting with high levels of deprivation; as such, our findings may not be generalisable across other populations. Although the final selected sample was roughly representative of the sample population, a substantial proportion of eligible women opted not to participate in this research, which may have introduced participation bias. Further, the nature of the purposive method for this study was such that a high number of people with experience of interpersonal abuse were selected, in order to achieve saturation of themes. It is also notable that a number of women did not recall being asked the Whooley questions and were therefore unable to participate in the current research; this may be suggestive of selective enquiry, and should be explored further. All findings should be considered within the context of the cited epistemological and individual approaches of the analytical researchers.

Conclusion

In sum, case identification with the Whooley screening at antenatal booking was considered acceptable, but although there were no objections to being asked the questions, some women found the experience of answering them difficult. This may be partly related to UK midwives' lack of confidence and competence in conducting mental

health enquiry. Women may experience increased difficulty on account of their personal experience with mental health problems or abuse, though a number of factors were identified that can contribute to positive experiences of disclosure, often in spite of difficulty. We recommend that midwives reassure women that any mental health concerns can be discussed and supported throughout the parenting process. Validating and normalising disclosures of mental health problems is of primary importance for acknowledging and understanding women's worries, and for exploring appropriate or desired avenues of support.

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